Adult Mental Health Workgroup Minutes

Meeting #3
September 20, 2011, 10:00 am to 3:15 pm
United Way
Des Moines, IA

MINUTES

Attendance

Workgroup Members: Deb Albrecht, Christopher Atchison, Lynne Baltzer, Jerry Bartruff, Teresa Bomhoff, Gilbert Cerveny, Lynn Ferrell, Dr. Michael Flaum, Chris Hoffman, Chuck Palmer, Patrick Schmitz, Kathy Stone

Legislative Representation: Renee Schulte, State Representative, House District 37 (Linn County); Jack Hatch, State Senator, Senate District 33, (Polk County), Co-chairs of the Legislative Interim Committee on MHDS Redesign; Joel Fry, State Representative, House District 95 (Clarke County)

Facilitator: Kevin Martone, Technical Assistance Collaborative (TAC)

DHS Staff: Pam Alger, Theresa Armstrong, Dennis Janssen, Jeannie Kerber, Laura Larkin, Richard Shults

Guest Speakers: Nicki Killoren and Theresa Hemann, Dave's Place, Keokuk; Vivian Davis, Chatham Oaks, Iowa City; Dr. Brian Kaskie, University of Iowa Center on Aging

Other Attendees:

Jennifer Bauer	CANDEO
Linda Brundies	Iowa Ombudsman
Amy Campbell	Iowa Psych Association/League of Women Voters
Melissa Conley	Chatham Oaks, Iowa City
Clara Czerwionka	UIHC/Tanager Place
Deb Dixon	Iowa Dept. of Inspection and Appeals
Bob Emley	Grand View University
Michelle Fiegl	PEERS in Council Bluffs
Kay Grotheo	AMOS MH
Gayla Harken	Story County Community Life
Ken Hyndman	Des Moines County CPC

Todd Lange	Iowa Office of Consumer Affairs
Adele Lenane	Hillcrest Wellness Center
Janet Lindseth	
Sherri Nielsen	Easter Seals of Iowa
Barbara Murphy	Harmony House
Liz O'Hara	Center for Disabilities and Development (CDD)
Kelley Pennington	Magellan Health
Jessica Perry	Hillcrest Family Services/Peer Support Training Academy
Jim Rixner	Siouxland Mental Health
Jenny Schulte	Advocacy Strategies
Jeff Schulz	SMG Group
Nicole Schultz	Iowa Pharmacy Association
Lisa Sieren	United Way
Deb Eckerman Slack	Iowa State Association of Counties/County Case Management
Kim Scorza	Seasons Center
Deanna Triplett	Iowa Behavioral Health Association
Karen Walters-Crammond	Polk County Health Services
Michelle Zuerlein	United States Psychiatric Rehabilitation Assn. (USPRA)

Meeting Summary

Review of Regional Meetings Regarding Mental Health And Disability System Redesign

Director Palmer discussed the listening post meetings which occurred on Sept. 16 with consumers and advocates in Iowa City and Cedar Rapids. The Office of Consumer Affairs was thanked for its organization of the meetings. - Approximately 110 individuals in Cedar Rapids and 80 in Iowa City attended the meetings. As a result of these meetings, there was a request that more information be provided to the workgroup regarding the role of Residential Care Facilities (RCF's) in the mental health system and if they function as a subacute level of care. Presenters from several residential facilities that serve individuals with mental illness will provide information to the workgroup today about the services and supports offered by these programs.

Rick Shults, the new Division Administrator for Iowa Department of Human Services, Division of Mental Health and Disability Services, was introduced to the group by Director Palmer. He began his position with the state on Sept. 19.

Director Palmer reminded the group that there is not much time left for the workgroup process. The interim legislative committee has started meeting and will be expecting workgroup recommendations in October. The group needs to get core services defined, define what form subacute services will take, and how the redesigned system will function, especially in the rural areas.

Review of Other Workgroups Activities
Kevin Martone provided a review of the other workgroups' progress.

- Adult Intellectual Disability is also working on defining core services.

- The Children's Disability workgroup is beginning to drill down to gaps in services and is considering what services it would take to bring kids home from out of state as well as the transition from child to adult systems.

- Regional did not meet last week.

Functional Assessment Tool Sub-Committee Report
The subcommittee will meet after this meeting today and provide a report at the next meeting.

Recommended List of Outcomes and Performance and Quality Measures:
Kevin reviewed the outcomes draft document and requested comment regarding what is and should be collected in the system. Kevin commented this it is to the workgroup's benefit to focus on outcomes that will define the service system. The workgroup needs to identify what they think should be measured. He stated that it is difficult as an outsider to figure out what data is being collected or what performance measures are already in place. It seems that the intellectual disability system has more clearly defined outcomes and performance measures, largely as a result of requirements of the waiver services.

Workgroup Comments
- The state should consider the burden on providers to collect data for outcomes and performance measures. It is requested that any new performance measures be consistent with data that is already collected.
- This appears to be a good list, but it seems to be more about values than outcomes, doesn't seem measurable.
- There is a statement in the draft document regarding self-direction. A workgroup member questioned what that meant for the mental health system. That statement was perceived to be more related to the Intellectual Disability system; however, it has not been ruled in or out of the proposed mental health system.
- Providers have struggled in the past to identify outcomes. There is an interest in hearing about other states successes in implementing outcomes measures.
- We have to figure out how to pay for this. The Legislature wants to determine how to get the most impact from funds spent. There needs to be measurable outcomes.
- The community mental health centers have been collecting CHI data, have those measures been compared to what is being considered for outcome measures?
- Clients may not understand what the CHI is, although if a client is not served by Medicaid, they might not be offered it.
- It was explained that providers who receive the Mental Health Block Grant and BHIS have to use the CHI or CHI-C to monitor client assessment of progress. It is usually offered at baseline and every 6 months. It is submitted to Magellan,

and is also available to providers to monitor agency outcomes as well as individual client outcomes. A report is also available to the client.

- Is this the same information that the substance abuse system gathers? It is one tool among several, but substance abuse is not currently using it.
- If we had a co-occurring system, wouldn't we want one tool that gathers the same information across the mental health and substance abuse systems?
- CHI does have some substance abuse questions.
- Are there key indicators that universally apply across systems? The group generally agreed there are some.
- Counties submit large amount of data to MHDS, unsure what it is used for other than meeting the requirement for money to be released. Lynn Ferrell and Dr. Flaum examined the data elements being gathered several years ago (approx. March 2006). They found that it was difficult to measure client satisfaction but did some cross-county comparisons. It was requested that the report be made available. It is unclear if a formal report was done.
- Does the data currently gathered really show outcomes at the client and service level?
- The Legislature appropriated 3 million for Medicaid to draw down 30 million to update the management information system.
- The connection between values and outcomes should be based on the Olmstead plan. It was suggested that it would be Important to have 4-6 key indicators- related to core areas like criminal justice involvement, housing, physical health, hospitalization, employment/education, and functioning.
- How do we hear what the consumer thinks about the system and their perceptions of care? The state tried the ICOMS system, which did not work. There needs to be a process to gather data on at least the 4-6 core outcomes.
- The data should be easily explained.
- Data is gathered from counties but the vast majority of clients are not county funded. Community mental health centers send a large amount of data to Medicaid- private pay clients are also offered the CHI. The costs to the provider of data collection (a non-billable service) in a fee for service environment should be considered.
- Question was asked regarding where Polk County obtains data for their outcome measures. It is a combination of CPC application data and information that case managers report into their data system. For instance, all case managers enter information regarding if clients have the required yearly physical. For report cards on providers, that information comes from the provider. It does not appear that other counties are doing this type of outcomes reporting.
- Director Palmer commented: The group should think about this as a regional system. The region will receive funds from the state to contract out to providers. There will need to be a standardized set of outcomes, consistent with Olmstead, easily understood, and concise. The system will also require a standardized set of performance measures related to outcomes that also lines up with current reporting of outcomes and performance measures. That will help the regional authority gauge effectiveness of services from the client and the provider level. Measures need to be consistent so they can be aggregated at the state and regional level for legislative and state leadership decision making. This can be

defined now in a process or it can be built into a recommendation and then the Legislature would probably give it back to the workgroup to figure out. The workgroup could have a year to figure it out. The workgroup should decide how far it wants to go in defining it and how consistent the outcomes and measures should be across the substance abuse, mental health, and intellectual disability systems. The workgroup should not focus on a specific tool for measurement and assessment, it is suggested that they make the recommendation without including these details.

Workgroup Comments

- Should a subgroup form to look at old reports regarding outcomes?
- Director Palmer replied that the workgroup should be very clear about what they want to measure, and then look at tools or processes to gather that information.
- If the state moves to a regional system, would the region would report on standardized domains?
- What is the definition of performance measures?
- Outcome could relate to domain areas but performance measure is the actual measure.
- Kevin questioned the group, In terms of regional structure, would the region gather the data and be the central repository of data, or would that reside with the State?
- Director Palmer stated that the state or region could be the repository, and issues related to collecting and managing data were discussed. There is not a great capacity to aggregate data currently. The legislatively mandated data workgroup is also to meet. It currently includes only DHS, IDPH, and the counties. It may need to be broadened in scope.

Workgroup Comments

- There is also an issue with services funded by other payers. How will data get to the regions if the services aren't publicly funded? Also, DHS needs to consider how consumer/family data should be gathered? Discussion of costs of collecting data at the state, regional and provider level.
- It was suggested that the legislature and state should know how many people have certain diagnoses. How do you find out how many people have Aspergers or a specific diagnosis? A comment was made that it is not readily available for any medical diagnosis.
- It is difficult to figure out funding when there is no central data repository to identify what the needs are. There needs to be a data driven conversation.
- The Legislature just passed legislation to authorize gathering of health care data to compare costs and types of procedures. They may need to consider expanding scope of this data collection.
- There is a danger of gathering data and not using it. We want a system that learns from the data, how do we set up a structure that ensures that the data will be used effectively?

Kevin displayed a triangle diagram with DHS, Medicaid and the regions as the key points needing access to data. What are the safeguards to ensure that DHS only gathers the data that is needed and used? The State should review data collected to ensure it is only gathering needed data. What does it cost to provide a service? How are units of service defined? They are currently defined differently by provider and payer sources. How does the region/state level the playing field? Lack of consistency makes it difficult to measure performance equally across the state. Some states build performance measures and financial incentives into their contracts.

Workgroup Comments

- Is this model three dimensional, to include those who are not tied into payment structure of DHS or Medicaid, such as those served by community health centers or substance abuse providers?
- Uncompensated care should also be included.
- In the substance abuse system, the payment system/data system is the same as providers report encounters, not claims. Is it necessary to have a separate data collection system from the claims or encounter data? If everything is entered in claims, it would be more efficient. How would the system gather data that isn't based on payment claims?
- Most states use Medicaid data as part of outcomes review process.
- We can't coordinate their care if we don't know what services they are receiving.
- Electronic Health Records could solve this and health exchanges may also be useful in this effort.
- Need to know what the incidence and prevalence of conditions is.
- Director Palmer stated that the group should set out the parameters of performance measures/outcomes, recommend a process to legislators, then they will ask the group to set the details.
- Jerry Bartruff stated that the Iowa Dept. of Corrections started a data system in 1996. It tracks the offender through the system. It is a seamless case management and data system. It looks at results of treatment, stability of housing, employment, drug use, measuring them at different levels to look at outcomes in district, case manager level, and The Electronic Health Record is also included. The Dept. of Corrections has started sharing that data with other departments. Currently, only state corrections staff enter into it right now. The cost is significant but worthwhile.
- Although the primary focus is clients that the state will pay for, we need to collect data on all individuals so services can be provided to those who need it. Medicare clients who need supportive services need to be considered also.
- We need to look at all individuals receiving services through regional contracted agencies regardless of payment source.
- We need to get the bigger picture of who is receiving services.
- What is the vision, the final outcome wanted?
- Providers need to identify what needs to be eliminated from current data collection before more items are added. Identify what is used and not used and if they know what the purpose of gathering the data is.

- Some states are doing public “report cards” on outcomes, specifically comparing providers.
- Readmission and employment rates could be outcomes indicators.

Recommended List of Core Services

As a result of the regional meetings held last week, questions were raised about the role of Residential Care Facilities and Intermediate Care Facilities in the core service domains identified so far. Two facilities sent representatives to the workgroup meeting to provide more information about their services.

Guest speakers-Nikki Killoren and Theresa Hemann from Dave’s Place, an Intermediate Care Facility for Persons with Mental Illness (ICF-PMI) in Keokuk, IA presented information about their facility and the role of their facility in the mental health system.

Dave’s Place provides the following services:

- 24-hour nursing.
- Behavior modification and a level system for behavior management.
- Psychiatric nursing care.
- Medication monitoring and management.
- Independent skill building.
- Focus on holistic care– planning to break ground for a wellness center in the near future.
- Clients are referred who have been refused at other facilities.
- Average length of stay is 3-4 months. The facility does not expect long lengths of stay; rather the goal is to prepare individuals to move to more independent living settings.
- The facility can provide these services at a lower cost than inpatient acute psychiatric care.

Workgroup Comments

- There is a shortage of beds right now in the acute care system with the current services that are in place.
- 10% of individuals occupy 50% of available bed space.
- ICF-PMI level of care was developed to help fill the gap between RCF’s and Acute Care settings.
- MHI’s used to fill this gap.

Guest Speaker-Vivian Davis, Chatham Oaks Residential Care Facility (RCF), Iowa City, IA presented information regarding Residential Care Facilities role in the current system:

- There is a concern about RCF's not being included in the core service domains identified so far.
- They do play a vital role in providing housing and supports for individuals with mental illness.
- Statistics for Chatham Oaks: it is licensed for 104- average daily census of 75. Majority of referrals are from acute care psychiatric hospitals. About 60% of referrals that are not accepted.
- Elopements are a big problem for their facility.
- There is a lack of low income housing for individuals with mental illness. Chatham Oaks built two apartment complexes for individuals with mental illness and is considering building two more. Individuals receive services and supports there.
- Ms. Davis referenced a study done in 2010 regarding RCF's that was submitted to the Legislature. The workgroup was not familiar with this report.
- She believes RCF's should be in core services under community living.
- Many RCF's are providing services to those with mental illness, some with intellectual disabilities but more with mental illness. The acuity of people being referred is getting more serious.
- Chatham Oaks would like to develop more of a subacute level but no such level exists in current licensure. It is Ms. Davis's opinion that ICF-PMI is too restrictive, that RCF-PMI doesn't work; however, she would recommend some kind of locked subacute facility for those individuals who are elopement risks.
- They are concerned about funding. RCF's are primarily funded by counties and it is unclear what the future is for that funding.
- Ms. Davis is also a parent of a child with mental illness. He has been in a PMIC twice, hospitalized 4 times and has had many services but could not be kept safe in the home.
- An RCF provides a much lower level of supervision than ICF-PM. ICF-PMI's are also not locked facilities but Dave's Place does have alarms on the doors and delayed egress.
- Comment from Gayla Harken, Story County Comm. Life which operates an RCF. Their clients are also most all referred from the MHI. The RCF appears to be providing the subacute level of care in order to help individuals return to community settings. This is not a long term placement anymore. There are 1,100 individuals living in RCF's and most are county funded. How do we make sure they are still served if the system is redesigned? The RCF is currently the de facto subacute/crisis stabilization.

Workgroup Comments

- When a referral comes in who authorizes or determines that the person needs this level of care?
- For ICF-PMI, they receive a PASSR level 2 assessment. RCF's don't require PASSR Level 2 assessments. Some individuals have a physician's order for this type of care.
- We have 5,000 RCF beds in the state but don't have consistent subacute services.
- The larger facilities are considered Institutions for Mental Diseases and therefore ineligible for Medicaid reimbursement. Some have also been targeted in Olmstead lawsuits.

Group Discussion of Recommendations for Subacute Level of Care and Crisis Stabilization

- Director Palmer discussed the 60% of referrals not accepted by RCF's mentioned in the Chatham Oaks presentation. Are these the individuals who need subacute services?
- Oakdale also provides some care for individuals who complete their criminal sentences but are committed civilly and are not appropriate for the MHI's.
- Question was raised, Does the group identify subacute as a short or long term type of placement?
- Polk County is serving individuals who are not appropriate for RCF's in 3 -4 bed residences under the habilitation waiver. These individuals are doing better than in facilities. Do we define this as a level of support-as opposed to a level of licensure?
- The LOCUS functional assessment doesn't define this type of service.

Questions to the Workgroup

- What does a region need to support this service?
- How do we build wraparound supports around a person in the community? Many people can be served in their own residence, in home, or in smaller shared living residences with the right wraparound supports. This is consistent with Olmstead principles.
- How do we keep individuals in small residential settings?
- Would a region contract with a provider to lease a facility, or does the client enter a lease?

Workgroup Comments

- What will the process be to figure out what services people need, especially during hospitalization?

- Ultimately the goal is to support the individual returning to his/her own home, possibly with supports.
- Some facilities have types of care based on lengths of stay.
- Intent of RCF-PMI level of care was to provide a more skilled level of care.
- Was the intent of SF 525 to identify subacute as a diversion from inpatient? The intent was for it to be both step down and diversion.

Question to the workgroup: Does Iowa have the 24-hour group care level as some other states do? It appears to be more intensive than basic RCF level of care.

- Polk County is using habilitation to fund residences for difficult to serve clients instead of increasing bed capacity.
- We have criteria for admittance to an acute care hospital. Subacute would be for those people who are just below that level. The group needs clarification on what is meant by subacute and crisis stabilization.

The legislators present were asked what the legislative intent was regarding subacute care. Rep. Schulte responded that they were referring to services for people who are stuck in acute care and people who need to be diverted from acute care. She states there is a need for a discussion of the functionality of current system beds. What is the purpose of the MHI's, are they really acute beds or do they provide subacute services also?

Discussion of Differences Between Crisis Stabilization and Subacute

1. Crisis diversion/residential/stabilization: short term purpose is to get person back to the community.
2. Subacute-more extended stays, higher level of needs.
    - Shouldn't keep the person in crisis stabilization longer than they would stay in an acute care setting otherwise inpatient capacity could become backed up even further. However, need to wrap services around them after they leave that setting.

Workgroup Comments

- Average length of stay in inpatient has declined over time from up to 30 days to approximately 7 days.
- Does there need to be an intermediate level of care?
- Concerned about distance from communities if services are regionalized.
- Peer-operated programs such as the living room model have shown promise.
- Discussion regarding how long a crisis stabilization/residential program should be? Suggestions ranged from as little as 36 hours to 3-4 weeks for complex individuals. Effects of an Illegal drug may linger longer than that.

- Concerned that five days may not be enough. It takes longer to get services organized, but that is a system problem, not a patient problem. If longer period of stabilization is needed, then a step-down to sub-acute is more appropriate.
- That is similar to the situation where individuals leaving hospitals are recommended to see a psychiatrist immediately but there are no openings for several months.
- If a system has client and family at the center, there should be enough flexibility to wrap services around them.
- What do we need to establish this program?

Question to the workgroup: If a region puts out an RFP for crisis stabilization services, how would a provider develop a program assuming that the funding was sufficient? Director Palmer added that the workgroup should assume that the cost of the services is being spent somewhere, probably at a higher level.

- The previous RFP for crisis services was not successful because there was not enough funding to provide what was asked for.
- Teresa Bomhoff asked Todd Lange to talk about Hillcrest Crisis Stabilization program.
- Todd gave a brief overview. Peer support specialists and clinicians work together as a team, using the Hillcrest wellness center as a base, and providing some limited mobile response.

Question to the workgroup: How many crisis residential programs would be needed per region?

- The group thought there should be at least one but it is difficult to say without knowing the size of the regions.
- If you have more than a certain number of individuals longer than 24 hours, have to have licensure and there is no licensure for this right now.
- There would need to be rules on what type of behaviors are accepted, and how elopement is addressed**.**
- If you have some type of mobile screening service, and somebody is referred to crisis services, who controls access? Is it the region, or the crisis provider? Somebody has manage and know where the beds are.
- Suggestion to try to keep services within one organization because this would be better for the client who might feel more comfortable if all services are within one organization.
- Clients need seamless transitions. People get tired of doing intakes with different agencies.
- Kevin suggested it might not be possible for one agency doing everything.

- Pathways' 18 bed substance abuse residential program has 75% of people on psychotropic drugs. These types of programs are also providing subacute care for individuals with mental health needs.

Question to the workgroup: If a psychiatric emergency screening service is started in each region, does it make sense for them to provide the crisis stabilization also? Do regional authorities or case managers decide where people go for services?

Workgroup Comments

- How do we handle agencies not wanting to take clients from other agencies for needed services?
- Health homes may encourage responsibility for overall health of client not just their part of the treatment. There may be financial incentives in health homes that encourage this.
- Currently an incentive to serve the population is a Magellan oversight.
- Concern was expressed that if you build beds, you will fill them. Polk County decided to focus on mobile crisis and flexible funds rather than pay for beds. If an individual needs crisis stabilization, the county rents a hotel room and has staff stay there with the individual.
- Dr. Flaum provided a chart that identified differences between crisis stabilization and subacute levels of care. The function of both was the same-diversion and step down from acute care settings. Crisis stabilization could be provided for individuals whose psychiatric illness is in an acute stage, are more medically stable, and with a planned shorter length of stay. Dr. Flaum also identified the subset of patients served in acute care settings that remain in the hospital for excessively long stays due to no available placements. These individuals are perceived as too aggressive to self or others to be served in RCF's, may have other co-occurring conditions such as intellectual disability or brain injury, and do not fit anywhere in the current system. They need secure and supervised settings. Secure was defined as probably a locked facility, but this triggers Olmstead and Medicaid funding issues. The MHI's used to provide this, but generally do not anymore. It was noted that this profile also applies to some of the children served in out of state facilities.
- Director Palmer stated that the Legislature thinks there is promise in subacute. If it is going to be a core service, the workgroup has to define it enough for the Legislature to make a decision. This means defining what is it, is it a core service, and could a regional administrator write an RFP to procure it?
- Rep. Schulte: Indiana has 20 regions and 92 counties. That state has crisis services in every county but it looks different in different places. The

Legislature wants enough flexibility to allow different methods in different areas but gets to same outcomes, still meets core requirements.
- The SAMHSA good and modern service array provides a list of options to choose from.
- The list should Indicate which core services are being presently offered.

Kevin Asked the Group to Define the Minimum Expectations for Crisis Services

- 24-hour crisis response hotline/statewide number was suggested while some participants thought crisis response should be handled regionally or locally by local providers. In some areas, CMHC's work with hospitals to staff crisis lines.
- Kevin has seen it operated both ways- statewide or regional. Regardless of which type is chosen, handoff to appropriate services is critical. After that handoff is made, it might be preferred to have one provider provide mobile screening, commitment processing, and any other crisis oriented services.

For the next meeting, Kevin asked the group to look at the table of core services and be prepared to identify what should be kept, added and removed. For the next five years, think about what is not there today and how do we prioritize what should be added. What should be added first?

Guest Speaker-Dr. Brian Kaskie, University of Iowa Center on Aging

Dr. Kaskie presented a PowerPoint presentation and summarized issues regarding older adults with mental health needs, and recent studies completed regarding the aging population in Iowa.

- In the past, professionals didn't know how to address mental health and substance use problems in older adults when they were seen in emergency rooms. The typical response was to overmedicate them.
- Iowa is an older state with more people over age 85 per capita than any other state. This is continuing to increase.
- Older adults' needs are more difficult. They are more entrenched in behaviors and are more medically complex. Aging causes changes to your brain, in addition to complications related to mental illness.
- The systems don't know what to do with them. They present with co-morbidity-chronic/serious mental illness plus physical health issues. They are more difficult to treat.
- Suicide rates are highest for older adult males.
- It used to be the perception that older adults didn't benefit from treatment. They were diagnosed with organic brain syndrome which is not a valid diagnosis and not offered active treatment.

- Where do the older adults receive care? Inpatient mental health units, nursing homes, and hospital swing beds. Iowa has the highest number per capita of hospital beds and nursing homes in the country.
- Who do they receive care from? Family practice/general practitioners who usually have little or no training in older adults' mental health needs.
- They may be prescribed medication, may get other services, or not. Most who receive a diagnosis receive no follow up care. People touch the system once and are then let go.
- This is the fastest growing population of Iowans. Half of people in nursing homes have dementia and behavior issues. Specialized training is needed. There are fewer than 10 geriatric psychiatrists in the state.
- Responsibility for funding-County system decides who to serve-they generally don't serve older adults. DHS-Division of Mental Health and Disability Services (MHDS) is the State Mental Health Authority but other departments are also involved including Medicaid, Department of Inspections and Appeals, Iowa Department of Public Health, and Iowa Department of Aging. MHDS has used the Mental Health Block Grant to support training and implementation of EBP's for older adults with mental health needs.
- Medicaid is a primary payer and has now carved out Magellan funds for older Medicaid beneficiaries. There are approximately 30,000 Iowans over 65 on Medicaid. Prevalence rates indicate that about 3,000 should have been served; in reality only about 300 have received services funded by Magellan in the first year of this plan.
- PASSR requires evaluation for those with a primary mental health diagnosis to be admitted to nursing homes. There are federal mandates on nursing homes. They are to work on getting people to least restrictive settings but nothing has changed at the community level regarding availability of services. Magellan may need to do more outreach so older adults know that additional services are available.
- There is not a lot of oversight of the service usage pattern for older adults. MHDS and IME have not provided data on usage

Dr. Kaskie's suggestions made to address these issues include:

- There should be continued research to identify strengths and needs of the system.
- It should be understood that older adults' needs are not the same as younger adults.
- Older adults typically won't go to mental health service providers. Those who have late onset of mental illness are mainly seen in primary care settings.
- Integration of mental health care and primary care is important.

- Primary care needs more back up and support to deal with older adults' mental health needs.
- All Iowa hospitals are certified as critical access hospitals so they don't lose money on Medicare services.
- Functional assessments might work better for older adults than straight diagnosis criteria.
- The Elderly Waiver doesn't seem to support mental health needs, more focused on case management and living supports. People are not being referred to mental health services because services are not available.

Workgroup Comment

- Does it make sense to train Area Agency on Aging staff to meet older adults mental health needs as they are the professionals who work with individuals on the waiver? Dr. Kaskie responded yes and no as individuals may need more specialized mental health care than the AAA staff could provide.

Public Comment

Comment: Availability of swing beds in hospitals may assist with discharge planning. Also one of the reasons we may not see as many older adults in the mental health system is that individuals with chronic mental illness tend to have shorter life spans. There needs to be a focus on developing public/private partnerships. Private providers and family practice doctors provide a large amount of care but are not part of this conversation. All crises are local. People want to know that they are talking to someone who knows the area. There is concern that a statewide crisis line will be a failure and need local providers and expertise to manage crisis.

Comment: Regarding Dave's Place ICF-PMI: This facility takes medically challenging and aggressive individuals but takes clients with other needs as well. The goal of the ICF-PMI is also to return the client to the community.

Comment: Regarding core services definitions, psychiatric rehabilitation can be offered in any treatment or residential setting. It is a philosophy as well as a service. Additionally, people who work in RCF's do not receive enough training for working with people with mental illness. Peer support specialists have more training than people working in RCF's.

Comment: Individuals with Down's Syndrome and Alzheimer's/dementia symptoms are a difficult population to serve and one that is increasing due to better care of these individuals. They end up on psychiatric inpatient units but then have no place to go after that.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.